DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 42000 (Rev. 09/02)

STATE OF WISCONSIN
Telephone (608) 267-5148
Fax (608) 267-9493

VACCINE ORDER

INSTRUCTIONS Order the number of doses **(not vials)** of vaccine that are needed. If Vaccine Information Statements are needed, indicate the quantity in the appropriate space below. **The vaccine order should be for a 2-month supply. Allow 2 weeks for delivery**. Sign and return completed order to the address below or Fax.
(Note: A public provider is a health department, tribal clinic or Federally Qualified Health Center.)

Name of Agency Requesting Vaccine(s)		PIN No.
Street Address		
City	State	Zip

Public and Private Providers		**Private Providers Only**	
Vaccine	**Doses Requested**	**Vaccine**	**Doses Requested**
Td (Adult)		DTaP (GSK – Infanrix)	
IPV		DTaP (Aventis Pasteur-Tripedia)	
MMR		DTaP (Aventis -DAPTACEL)	
Hep B - Hib (Merck & Company) (Comvax)		Hep B (GSK-ENGERIX-B 0-18 years)	
DT (Pediatric)		Hep B (Merck & Company) – Recombivax HB 0-18 years)	
Varicella		Hib (Merck & Company) PedvaxHIB)	
Hep B – Adult		Hib (Wyeth – HibTITER)	
Pneumococcal: Conjugate (PCV7)	Limited quantity**	Hib (Aventis Pasteur– ActHIB)	

Public Providers Only	
Vaccine	**Doses Requested**
DTaP (GSK-Infanrix)	
Hep B (GSK-ENGERIX-B 0-18 years)	
Hib (Merck & Company) PedvaxHIB)	

Vaccine Information Statements

Indicate the quantity forms needed. Do not indicate by marking with a check (Ö) mark. Forms are packaged 100 forms per pad.

DTaP _____ Td _____
Hib _____ Polio _____
MMR _____ Varicella _____
Hep B _____
Pneumococcal: Conjugate_____
Vaccine Administration Record (Signature form) _____

SIGNATURE – Person Completing this order	Telephone ( )	FAX: ( )	Date Signed

Return completed form to:

Wisconsin Immunization Program
Bureau of Communicable Diseases
P. O. Box 2659
Madison, WI 53701-2659
Fax (608) 267-9493

**Indicate the # of doses of Prevnar you currently have on hand at this time_____